



WHAT KIND OF FATHER WILL I BE?

We all have heroes or role models. For many men, it might be a professional athlete or coach, a parent or older sibling. We try to copy their actions and learn from them. As a new dad, we often look to our own fathers as a role model. For better or worse, the experience we had with our own fathers forms the basis for our own performance.

Times have changed since our fathers were new dads. Generally, they were excluded from the delivery room, waited a week to take mom and baby home, and rarely changed a diaper. Mothers-in-law came to help out and dad returned to work with no time off. Dad resumed his role as moneymaker and disciplinarian, getting involved with his children when they were old enough to play catch.



Today, new dads are taking a more active role in their child's life. They want to be there for their kids. As Joe, a 42-year-old truck driver, noted during a Boot Camp session, "My dad really never did anything except work all the time, so I want to be the opposite of that with my child."

As another Boot Camp participant (Mike, a 31-year-old network administrator) added, "My dad worked hard, but when he was home he liked to be with me. I could always talk to him about stuff. I still can. I hope to raise my son the same way."

Boot Camp is a class for dads with babies and dads expecting babies. For more information, call First Steps/Step Ahead of Wells County at 1-800-417-2774 or visit the Boot Camp web site: <http://www.newdads.com>

*Submitted by Bill Horan,
Boot Camp Coach.*



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First Steps
Indiana Children's
Special Health Care Services

KIDSteps Magazine is a quarterly publication of the Indiana First Steps Early Intervention System and the Indiana Children's Special Health Care Services Program.

INDIANA KIDSteps MAGAZINE

SPRING 2001



**SPECIAL ISSUE:
MEDICAL HOME INITIATIVE**

THIS MAGAZINE'S MISSION

The mission of this quarterly publication is to offer useful information to families, providers, service coordinators, medical professionals, and others who have special interest in the successes and challenges of early intervention and early childhood development in Indiana and neighboring states.

Welcome to KIDSteps Magazine.

Thanks for picking up this issue of KIDSteps. You are an important part of our success in creating and maintaining effective and comprehensive early intervention for all children in Indiana. We're glad you're on our team.

"Team" is the operative word in this issue as we focus on a program that partners parents, physicians, and community resources in creating a "medical home" for every child, notably those with special needs. "Medical Home" is the concept of providing children with health care services in a high-quality and cost effective manner through the joint efforts of the child's family and pediatrician. The program digs deep into the processes of early intervention through screenings and skills development in the treatment and handling of children with special needs. By definition, Medical Home is a network that makes early intervention resources and supports accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally-competent. As the name implies, Medical Home is the ideal combination of medicine and home that can positively influence the health and well being of a child.

Our thanks to the American Academy of Pediatrics for serving as the primary information and training resource for the Medical Home initiative – and to Dr. John Poncher and to Donna Gore Olsen of Indiana Parent Information Network for their insight and work in bringing Medical Home to Indiana families, children, and communities.

We applaud the brave determination of Jennifer Embry, a delightful little girl who was born three months prematurely and has hydrocephalus – an abnormal buildup of cerebrospinal fluid in the ventricles of her brain. You get to meet Jennifer on page 9 and learn about her tremendous improvements thanks to medical technology and the First Steps early intervention process. Our thanks to the Embry family and to Terry Rizen, their service coordinator in Evansville.

The early intervention and education efforts of Indiana First Steps and Children's Special Health Care Services are at work in your community, and we are thankful for team members like you.

Maureen G. Greer

Maureen Greer
Assistant Deputy Director,
Bureau of Child
Development,
First Steps

INDIANA KIDSteps MAGAZINE

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The federal Maternal and Child Health Bureau (MCHB) continues to approach the broad issue of helping children gain access to their health care needs. Understandably, the question quickly reaches into other areas, examining not only the needs of children, but also the needs of parents, physicians, and communities. Ultimately, we begin to fully realize the penetrating value of parent-physician partnerships in the interest of children's health.

In a cooperative agreement with the Bureau, the American Academy of Pediatrics (AAP) developed an initiative to help ensure that all children, particularly those with special needs, have health care services that are accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally-competent. The initiative is known as "Medical Home."

MEDICAL HOME PARTNERS PARENTS AND PHYSICIANS IN COMPASSION AND CARE

Upon first hearing the term "medical home," a doctor's office or health care center almost immediately comes to mind. On the contrary, a medical home is not a house or building or hospital. In reality, a medical home is an approach to providing health care services in a high-quality and cost effective manner. The medical home name implies joint accountability between the child's primary care physician and the family – a partnership that is the ideal combination of resources for children's special health care needs.

Children and families who have a medical home are able to receive the care that they need from a pediatrician or pediatric health care professional whom they trust. This partnership between pediatric health care professionals and parents enables both parties to identify and access all of the medical and non-medical services needed to help children reach their fullest developmental potential.

The medical home approach is founded on seven primary care competencies, ensuring that "health care for every child be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally-competent." In

some cases, a pediatric subspecialist can coordinate the

child's care with the primary care pediatrician and parents to provide a medical home. This works especially well for families with children who live in areas where it is not possible to meet with a pediatrician directly.

THE FIRST STEP: SCREENING AND EARLY INTERVENTION

According to a report in *Pediatrics* (Vol. 106, No. 2 Supplement, August 2000), approximately 4 million infants are born every year in the United States and undergo a variety of medical screenings to detect conditions that may threaten or negatively influence their long-term health. Health screening in general is an early identification activity that targets infants who are affected by certain genetic, metabolic, or infectious conditions. Early identification is the first step to early intervention that can significantly reduce developmental delays, disabilities, and mortality.

The "screening initiatives" of a medical home are focused on ensuring that all children are screened at the earliest age possible for hearing and vision loss, as well as metabolic and genetic disorders.

An important part of a child's medical home is the reassurance that each child receives appropriate screening,

Continued on page 4.

MEDICAL HOME PARTNERS PARENTS AND PHYSICIANS IN COMPASSION AND CARE

Continued from page 3.

treatment, and follow up for identified problems. Therefore, pediatricians and other primary care health professionals must be actively involved. It is the working partnership between the pediatrician or other primary care health professional and the child's family that assures the child will receive all medical, nonmedical, psychosocial, and educational support necessary.

“EVERY CHILD DESERVES A MEDICAL HOME”

To ensure success at the local level, the medical home initiative requires training. In answer, the AAP, Family Voices, the federal Maternal and Child Health Bureau, the National Association of Children's Hospitals and Related Institutions, and Shriners Hospitals for Children joined forces to develop the medical home training program entitled “Every Child Deserves a Medical Home.” In 1998 and 1999, the group launched its medical home test pilot and revised the program for national publication. Today, the training program continues to be implemented at all Shriners Hospitals and through a host of national children's advocacy networks such as the AAP state chapters, children's hospitals, parent advocacy organizations, and other local community-based networks.

The actual hands-on training is a collaboration of teams that have expertise in caring for children with special needs and that have policy experience related to managed care and children with special needs. The medical home training curriculum was intentionally written at a national level so that communities may customize and add local information as appropriate. The four-component curriculum targets the procedures in providing a medical home to children with special needs, including definitions of key concepts and practical strategies for implementing medical homes. The training can be implemented all at once in a single-day session or applied at various times. The flexible design of the curriculum enables organizations to customize the program length and target audience.

Ideally, pediatricians, family representatives, nurses, pediatric subspecialists, insurance administrators, government officials, and any other group of individuals working with children with special health care needs should consider the Medical Home Training Program. The program strives to:

- Provide knowledge to pediatric primary care providers (PCPs), pediatric health care providers, and families about how to ensure that children with special needs have medical homes in a managed care environment.
- Enhance skills for developing sustainable medical homes.
- Strengthen skills for identifying and working through financial and non-financial barriers to medical homes for children with special needs.
- Improve skills for identifying and developing community resources and networks.
- Illustrate the importance of a collaborative effort on behalf of pediatric health care professionals, families, communities, and managed care administrators.

The American Academy of Pediatrics offers a curriculum package at no charge to any individual or organization choosing to start a medical home initiative in their community. The package includes a facilitator training manual that features specific teaching points, examples, discussion questions, group exercises, case studies, and handouts with directions for their use during the session; participant training manual; a Power Point slide presentation; and marketing materials.

TECHNICAL ASSISTANCE BEHIND EVERY INITIATIVE

The medical home approach is bolstered by a comprehensive support system. Technical assistance is provided to anyone involved with the process of providing children with special needs with a medical home. Professionals are available to help parents, physicians, and communities on all levels by:

- Providing educational and advocacy materials about medical home.
- Identifying and helping to overcome any barriers.
- Linking individuals and communities with model medical home projects across the U.S.
- Facilitating training events.
- Coordinating planning meetings.
- Identifying local, state, and national funding resources.

HOW TO IMPLEMENT A MEDICAL HOME IN YOUR COMMUNITY

In January of 2001, AAP and the National Center of Medical Home Initiatives for Children with Special Needs assembled a team of pilot states to create models in which all children with special needs will receive care through a medical home by the year 2010. The goal of the project is to develop state initiatives that can be implemented in each state, creating a “template” that could be adopted and adapted by other states. The National Center is committed to promoting optimal care for children with special health care needs with pediatricians, parents, administrators, and other health care professionals playing the key role in implementing the medical home initiative.

The American Academy of Pediatrics web site offers an in-depth description of the medical home initiative. Log onto www.aap.org, click on “Community Pediatrics,” then select “Children with Special Needs.” You can also indicate your interest to get involved by using the site's online registration form or add your name to the mailing list by sending your name, address, telephone number, and email address via email to medical_home@aap.org or in writing to:

National Center of Medical Home Initiatives for
Children with Special Needs
American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove Village, IL 60007

THE SEVEN CORE CARE COMPONENTS OF A MEDICAL HOME PROGRAM

The American Academy of Pediatrics defines a medical home as the provision of care that meets each of the following criteria:

Accessible

Care is provided in the child's community.

All insurance, including Medicaid, is accepted and changes are accommodated.

Family-centered

Recognition that the family is the principal caregiver and the center of strength and support for children. Unbiased and complete information is shared on an ongoing basis.

Continuous

Same primary pediatric health care professionals are available from infancy through adolescence. Assistance with transitions to school, home, and adult services is provided.

Comprehensive

Health care is available 24 hours a day, 7 days a week.

Preventive, primary, and tertiary care needs are addressed.

Coordinated

Families are linked to support, educational, and community-based services. Information is centralized.

Compassionate

Concern for the well being of the child and family is expressed and demonstrated.

Culturally-competent

Family's cultural background is recognized, valued, and respected.

MEDICAL HOME: A PHYSICIAN'S VIEWPOINT

The Medical Home concept is a wonderful concept. The concept for me has the face of a sensitive pediatrician, a true gentleman in Hawaii – Cal Sia. Some 40 years ago, Cal talked about a movement in Hawaii to ensure that all children not only had medical care, but also a place that the children were known and comfortable – where their care was compassionate and comprehensive – a place that provided continuity like what pediatrics is all about.

More recently, the concept was adapted to children with special health care needs. The federal Maternal and Child Health Bureau and the American Academy of Pediatrics picked up the gauntlet. A great deal of time and effort has produced a lot of good stuff. Much has been written. The consummate resource has been established at the American Academy of Pediatrics, The National Center for the Medical Home Initiative.

Unfortunately, the practice of medicine has changed in those 40 years. The concept embodies a commitment that is perhaps stressed by 21st century primary care mode. Its shortcomings, however, are not a product of the concept itself, but rather the systems that are designed to support it. If quality is a consideration, the concept remains valid. It is the reality that needs an adjustment.

The concept says that the care provided in a medical home is comprehensive and serves infants, children, and adolescents through transition (to adult medicine in the case of pediatrics). It includes preventive care, growth and development assessment, anticipatory guidance, and appropriate screening, all over an extended period of time to enhance continuity. It is accessible 24 hours a day, 7 days a week, 52 weeks a year. A good medical home has working relationships with pediatric subspecialists. The medical home serves as a conduit for appropriate referrals, medical information to and from the consultant. The providers within the “medical home” evaluate the consultant’s recommendations and implement them within the context of the resources available within the family constellation and the community.

This implies that a medical home provider interacts with schools and community agencies to insure that special health needs

of the individual child care are addressed.

For some, this may seem more like a “wish list” than reality. It doesn’t take a rocket scientist to see how managed care impacts on such a concept. The adjustments providers feel they must make in order to compete and provide in this environment serve as barriers for access to quality medical homes. Employers frequently change insurance carriers forcing families to change providers, not only sending medical homes in disarray, but upsetting families and support systems, as well.

In order to assist families in making informed choices for special health care needs, systems exist at various levels. The ability of “systems” to function successfully depends upon a variety of factors. They must be flexible. They must communicate with providers, other systems, and families. There needs to be monitoring because we need to look at outcome data upon which successful strategies for systems management are built. We need to have the ability to identify special needs populations rather than relying on “best guess” estimates. Providers need to be adequately reimbursed.

Systems link medical homes to pediatric subspecialists and community-based resources, and they link families to financial alternatives. Medical homes by definition do not function in isolation – neither should the systems that are designed to support families and children. It may seem to you that I have complicated what started out to be an understandable and basic concept. That is more reality than intent.

We in Indiana are fortunately blessed with committed individuals working in concert for family and children with special health care needs. They have been consistent “players” dedicated to making the system work. They have not lost the focus of their endeavors, the child and his or her family. Still, there remains much to be done. Concepts tested by time need understanding; weary “soldiers” need reinforcements. Significant gaps remain between concept and reality. The task at-hand must forever be that of working together to close those gaps. The means to that end may not necessarily be more resources, but rather, more resourcefulness.

Dr. John R. Poncher is the Chair of the Indiana Chapter on Children with Disabilities. He served as an original member of the Medical Home Project Advisory Committee.

CREATING A MEDICAL HOME: A PARENT'S PERSPECTIVE

Awareness and communication are critical links between families, physicians, and community resources. The success of this triangular partnership relies heavily upon a medical home program bound by commitment and active participation of everyone involved.

Parents often become frustrated with physicians for their apparent lack of awareness of community resources or their reluctance to share information. Until recent years, some physicians discredited early intervention as not having significant proof or research results of treatment success. Yet, developments within the early intervention process continue to dispute these general assumptions and actually make it easier for physicians and health care providers to recognize the benefits of initiating early intervention and creating a medical home for children with special needs. Of increasing importance is that physicians know what specific resources are available within their community (such as First Steps service coordinators, Children’s Special Health care coordinators, Medicaid case managers, and so on) and be prepared to introduce parents of children with special needs to this network of early intervention opportunities.

Creating a successful medical home program in every community should be a priority among parents, physicians, child care providers, and early intervention resources. The American Academy of Pediatrics offers the following excerpt that identifies a parent’s common concerns and expectations in working with their physician. You can find this and more information on the on the Academy’s web site at www.aap.org, then select “Community Pediatrics” followed by selecting “Children with Special Needs.”

WHAT PARENTS WANT PHYSICIANS TO KNOW ABOUT THEIR CHILD WITH SPECIAL NEEDS

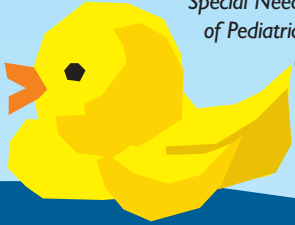
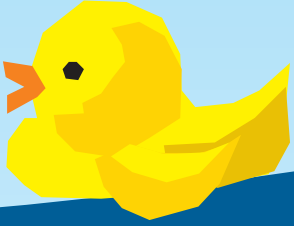
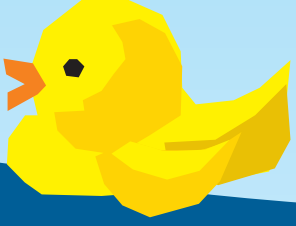
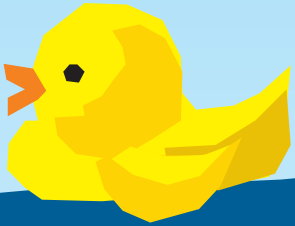
- Recognize my denial, anger, and healthy and natural response to grief.
- Accept that my child’s health care needs are only a part of my family’s priorities and that sometimes my family’s needs and concerns may take precedence.
- Value that I’m the expert on my child.
- Acknowledge that I am a competent partner in health care.

WHAT PARENTS NEED FROM THEIR CHILD'S PHYSICIAN

- Help me find the information I need to understand my child’s condition. My child’s condition is not temporary. I’ll be learning about it for a lifetime.
- Do not withhold or omit any information concerning the severity or extent of my child’s condition. Also, do not hesitate to use medical terms when necessary.
- Help me to understand the range of possibilities. Tell me the worst and best possible prognosis.
- Acknowledge my sense of urgency by responding quickly to requests for medical information, referrals, and so on so that appropriate services can begin or continue.
- Remind me of my child’s strengths from time to time. Collaborate with other professionals providing care for my child.
- If sometimes it seems that I expect you to be my social worker, psychiatrist, and omnipotent seer of the future ... well I do!

Content provided by Donna Gore-Olsen, Executive Director of The Indiana Parent Information Network and The American Academy of Pediatrics.

Source: “Physician: What Parents Want You to Know About Their Child With Special Needs,” American Academy of Pediatrics web site (www.aap.org), March 2001.



WHY DO WE NEED TO BE CONCERNED ABOUT LEAD POISONING IN HOOSIER CHILDREN?

Lead poisoning is a silent threat to children, producing damage without sudden and dramatic symptoms in its early stages. Lead is everywhere – in our homes, our soil, our workplaces, and even in our food and water. The majority of childhood lead poisoning occurs at home. While it is true that many children are poisoned by eating paint chips (they taste sweet), most children are poisoned by invisible lead dust created when lead paint deteriorates from age, is exposed to the elements, is damaged by water, is exposed by friction, or is created during home renovation.

WHAT IS LEAD POISONING AND HOW DOES IT CAUSE DAMAGE IN YOUNG CHILDREN?

Simply put, lead poisoning is the presence of too much lead in the body, which normally should contain no lead. The level of lead exposure in children is determined by measuring concentrations of lead in the blood. These levels are stated scientifically as micrograms of lead per deciliter of whole blood, or ug/dL. Exposure to lead adds up over time, accumulating a lead burden in the body. Lead enters the body largely through ingestion or inhalation.

Lead poisoning can have serious and long-term effects. Young children are more vulnerable to lead poisoning because they are more likely to be exposed, and the young developing brain is more susceptible to lead toxicity. Children absorb lead at a much greater rate than adults. Between the ages of 6 months and 4 years, children are most likely to engage in the hand-to-mouth behavior that exposes their bodies to lead.

The symptoms of lead poisoning can be mistaken for other childhood illnesses or can be attributed to other causes, such as poor diet, lead poisoning is often not suspected initially. Children may have lead poisoning without feeling or looking sick, or they may have symptoms such as headaches, irritability, tiredness, lack of appetite, vomiting, stomach aches, lack of muscle control, or convulsions, which may mimic other illnesses.

From 1994 to 1999, 185,000 Indiana children under age six were screened for elevated blood lead levels. Of these children, 8.2% had blood lead levels of 10 ug/dL, the level at which permanent damage begins. Lead poisoning in Indiana disproportionately impacts urban, low-income, and minority children who live in older housing or historical housing. It appears that most middle-class, suburban children are lead poisoned due to renovation repainting projects in their homes, by workers or their own parents who simply do not know safe practices for working with lead-based paint on older homes.

A WISE HEALTH TIP: HAVE YOUR CHILD TESTED FOR LEAD POISONING!

Written by Cathy Nordholm, M.S., CFRM, Director, Indiana Childhood Lead Poisoning Prevention Program, Indiana State Department of Health. For more information, please call 317-233-1250.

FAMILY IN THE SPOTLIGHT

JENNIFER EMBRY'S REMARKABLE RECOVERY

The news was not good for Sylvia and Eddie Embry and their daughter, Jennifer.

Born three months premature, Jennifer suffered from hydrocephalus – an abnormal buildup of cerebrospinal fluid (CSF) in the ventricles of the brain – more commonly known as “water on the brain.”

CSF is a watery fluid produced by the ventricles at a constant rate. This fluid is channeled into a space surrounding the brain to work as a cushion before being reabsorbed back into the blood stream. “Hydrocephalus” happens when the CSF pools as a result of a blockage in the circulation or an overproduction. The condition is either congenital (existing at birth) or acquired as the result of trauma to the brain after birth. As a result, hydrocephalus patients can suffer visual impairments, motor skill disabilities, or learning disabilities. In severe cases, such as baby Jennifer’s, the future can seem bleak since hydrocephalus is a lifelong condition where the patient is treated rather than cured. Treatment involves shunts that divert the fluid to another part of the body. Fortunately, the majority of newborns with hydrocephalus enjoy a normal life span with normal (or sometimes superior) intelligence and activities.

For little Jennifer, the shunts worked. After three months in an Evansville, Indiana, neonatal intensive care unit, her CSF had completely reabsorbed into the blood stream, and her brain tissue managed to correctly reposition itself – good news for a family in a fearful situation.

More good news came as the Embrys got involved in First Steps. Now at almost 18 months, Jennifer receives scheduled, in-home physical and developmental therapies. She has a large vocabulary for her age and is able to put words together and

speak plainly. Jennifer’s foremost delay is in walking, and her therapists work with her weekly to help develop those motor skills. A tiny sliver of Jennifer’s brain tissue is missing in the front, and it may be too early to tell if she will suffer any impairments, such as color blindness or depth perception, as a result. Possibly, other areas of the brain will absorb these responsibilities.

Sylvia is quick to credit their First Steps service coordinator, Terry Rizen, for getting Jennifer the help she needs. “At first, we were very scared,” explains Sylvia. “We didn’t know what to do or watch for regarding Jennifer’s condition, but the First Steps system and the therapists have brought peace to our minds. Our PT, Melissa Arseneaux, and DT, Tammi Nicholson, constantly provide me with ideas and skills to work with Jennifer. They show me different approaches and what to work on with her between therapies. We can’t thank them enough for helping us through a scary time.”

For now, Jennifer’s goal is to eat all of her favorite foods (which include everything except pizza) and play with her two older sisters, Quila and Kelsea.

“Jennifer is a lovable child,” Sylvia’s voice beams over the phone. “She loves to talk and play, and she definitely shows her frustration when she gets mad! She’s also a daddy’s girl – she absolutely lights up when he enters the room. We’re just so fortunate to have three really great children.”

For more information about hydrocephalus and the problems associated with this condition, check out The Hydrocephalus Foundation website at www.hydrocephalus.org or contact your local First Steps service coordinator.



Jennifer (center) with sisters Quila & Kelsea

“Enhancing the choice of early intervention services for infants and toddlers with special needs and their families through community involvement.”



*Governor's Interagency
Coordinating Council on
Infants and Toddlers*

INDIANA AWARDED MULTICULTURAL LEADERSHIP TRAINING GRANT

George Mason University has selected Indiana as one of four locations to participate in the Multicultural Leadership Teams: Families and Professionals Creating Culturally Responsive Practices. Submitted by the ICC Diversity Task Force, the application was supported by several agencies that already work closely with the ICC including the Department of Health, Department of Education, Healthy Families, Head Start, Prevent Child Abuse Indiana, and the Indiana Association for Infant and Toddler Mental Health.

A planning team is working to name a training team that will travel to Virginia this summer to participate in

a Multicultural Leadership Training Institute. The training team will return to Indiana and conduct sessions statewide in the coming year for First Steps stakeholders as well as other systems that impact young children and their families.

Simultaneously, the ICC is working with the Indiana Department of Health to survey local councils, system points of entry, providers and families regarding the make-up of the First Steps constituency. This research will provide great baseline data so that the impact of multicultural training can be measured. Thank you to everyone in the system that is responding to the survey when requested!

Children are very different from one another.

Don't worry if I am early or late in the ways I am growing. Help me practice new skills when you play with me. Most infants have the following skills at the end of 9 months. If you are concerned about what I do, talk to my doctor or nurse, or call the people at **First Steps**. If you don't know the number, call **1-800-441-7837**.

Watch for me to:

- ◆ sit for a few seconds without any help.
- ◆ feed myself a cracker, cereal or other foods I can eat with my fingers—I'm pretty messy.
- say *ma, ga, da, di, ba* and other sounds.
- ◆ pick up small things, like a Cheerio, using my whole hand in a raking motion.
- listen to people talking and try to make the same sounds they do.
- hold a small block in one hand and pass it to the other hand.
- ◆ look for something that I have dropped.
- ◆ hold onto something and stand for about 5 seconds.

You may notice that I also:

- ◆ get upset if you leave me, even if it's for a short time. I will feel better when you return.
- begin to drink juice from a cup.
- ◆ know which toys are mine.
- I don't like it when my toys are taken away.
- may be afraid of things that were O.K. before. I might be afraid of my bath, a sitter or the dark.
- ◆ may be stubborn sometimes. This is part of growing up.



Lawrence County First Steps Committee won 3rd Prize with their float in the Mitchell Persimmon Festival Parade held September 30, 2000. The parade is the second largest in the state of Indiana. The float featured the First Steps logo made entirely of bright red, blue, and white balloons. Two Lawrence County First Steps families rode the float. Special thanks go to Cathy Hawkins, Teresa Tolbert, Mary Ann West, Teresa Reynolds, Perry Reynolds, Tammy Roberts and Tracy Lee for all of their hard work.



UPCOMING TRAINING OPPORTUNITIES

Indiana First Steps along with Unified Training Systems (UTS) and the Indiana Parent Information Network (IPIN) provide many education and training opportunities for parents and providers throughout the year. Please check out the Events Calendar for Indiana's Early Childhood Community at :

<http://earlychildhoodmeetingplace.indiana.edu>

or

<http://www.iidc.indiana.edu/~ecc/uts/uts.html>

FIRST STEPS PROGRAMMATIC TRAINING:

Orientation to First Steps

- Service Coordination—Level 1
- Service Coordination—Level 2

Topical Issues:

- Infant Mental Health
- Advanced Practice of OT/PT
- Advanced Practice for OT/PT/SLP
- Advanced Practice for Cerebral Palsy
- Communication Methodologies Related to Hearing Loss

- Developmental Intervention for High Risk Newborns
- Advanced Feeding Issues
- Developmental Therapy Series
- LPCC Leadership Conference

IPIN Training:

- Health Care Financing
- Financial Case Management
 - Private Health Insurance
 - Public Health Insurance, i.e. Medicaid/Medicaid Waiver
- Article 7 Special Education Rights
- Parent Liaison Training

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